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M1700.100 INTRODUCTION

A. Administering Agency

The Department of Medical Assistance Services (DMAS) is responsible for the investigation and referral of fraudulent and erroneous payments made by the Medicaid Program. DMAS can recover any payment erroneously made for services received by a Medicaid recipient or former Medicaid recipient. Recovery can be made from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempted from collection efforts by State or Federal law or regulation.

A. Utilization Review

Recipients' utilization of all covered services is monitored regularly by DMAS. Whenever the utilization of services is unusually high, the claims for services are reviewed for medical necessity. If some services are considered not medically necessary, the recipient will be contacted by the DMAS Recipient Monitoring Unit.

DMAS also reviews hospital claims prior to payment to determine if the 21-day limit is exceeded or if the length of stay regulations are met. All provider claims are reviewed and audited after payment.

M1700.200 FRAUD

A. Definitions

Fraud is defined as follows:

"Whoever obtains, or attempts to obtain, or aids and abets a person in obtaining, by means of a willful false statement or representation, or by impersonation, or other fraudulent device, assistance or benefits from other programs designated under rules and regulations of the State Board of Social Services or State Board of Health to which he is not entitled, or fails to comply with the provisions of *63.2-522, 32.1-321.1, 32.1-321.2,.1-112,* shall be deemed guilty of larceny..." (Code of Virginia, §63.1-124).

"If at any time during the continuance of assistance there shall occur any change, including but not limited to, the possession of any property or the receipt of regular income by the recipient, in the circumstances upon which current eligibility or amount of assistance were determined, which would materially affect such determination, it shall be the duty of such recipient immediately to notify the local department of such change, and thereupon the local board may either cancel the assistance, or alter the amount thereof." (Code of Virginia, §63.1-112).

B. DMAS Responsibilities

1. Recipient Fraud

DMAS has sole responsibility for handling cases of suspected fraud by Medicaid recipients when eligibility for a public assistance payment is not involved (Medicaid only cases). Medicaid cases involving suspected fraud must be

referred to DMAS, Recipient *Audit* Unit, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, using the format for the Recipient Fraud/Non-Fraud Referral in Appendix 1 to this chapter. The following information must be provided:

- recipient's name and Medicaid number;
- recipient's social security number;
- reasons for and exact dates of ineligibility for Medicaid;
- *applicable Medicaid applications or review forms for the referral/ineligibility period;*
- *address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;*
- *relevant covered group, income, resource, and/or asset transfer documentation;*
- *any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and*
- *information obtained from the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.*

This format has been specifically designed to be used in conjunction with the DMAS Fraud Abuse Information Reporting System and the format must not be altered.

The current threshold for Administrative Recoveries of Medicaid fraud is $300.00. It is not feasible for DMAS to pursue cases with losses less than this threshold. If there is a question regarding the amount of the loss of Medicaid funds, the local agency must submit a Medicaid Claims Request (see Appendix 2 to this chapter) to DMAS and obtain the amount of the loss. The local agency should allow a three-week turnaround for the documents. There may be exceptional circumstances when claims can be provided within a shorter time, i.e. expedited trial dates. Once the information is received and it is determined that the loss exceeds the threshold for recovery, the local agency must send the Recipient Fraud/Non-Fraud Referral to DMAS.

There is **no** threshold for any case with criminal intent to defraud Medicaid.

2. Provider Fraud

Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients must be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General. A copy of the information sent to the Medicaid Fraud Control Unit in the Office of the Attorney General must be sent to the Provider Review Unit, Department of Medical Assistance Services.

3. Suspected Fraud Involving Recipients of Public Assistance

a. Temporary Assistance for Needy Families (TANF) and Auxiliary Grant (AG) Cases

Cases of suspected fraud involving ineligibility for a TANF or AG payment are the responsibility of the local department of social services. The local agency determines the period of ineligibility for Medicaid, and the DMAS Recipient Audit Unit provides the amount of Medicaid payments made. The amount of misspent Medicaid funds must be included in the TANF or AG fraud cases, whether the action results in prosecution or in voluntary restitution. The final disposition on all money payment fraud cases must be communicated to the Recipient Audit Unit, DMAS, no later than 5 business days after disposition for inclusion in federal reporting.

b. Food Stamps, General Relief (GR), Fuel, etc.

For suspected fraud involving Food Stamps, GR, Fuel, or other such assistance which does not directly relate to the provision of Medicaid, the local agency must notify the Recipient Audit Unit of the agency's action on the other assistance case so that Medicaid can take concurrent action if necessary.

C. Medicaid Ineligibility Following Fraud Conviction

1. Period of Eligibility

When an individual has been convicted of Medicaid fraud by a court, that individual will be ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage must be taken in the month of conviction or in the month the agency learns of the conviction, using cancel reason *0*14 *(42 United States Code §1320a-7b.(a)(6)(ii); 12 Virginia Administrative Code 30-10-70).*

2. Who is Ineligible

a. TANF or Families and Children (F&C) Cases

In a TANF or F&C Medicaid case, only the parent/caretaker will be ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment for the caretaker may not be affected.

b. Aged, Blind, Disabled (ABD) or Pregnant Women Cases

In an ABD or pregnant woman case, only the individual found guilty of Medicaid fraud will be ineligible. If only one spouse of a married couple is convicted, the eligibility of the innocent spouse is not affected.

3. Family Unit

If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.

M1700.300 NON-FRAUD RECOVERY

A. Definition

The Virginia State Plan for Medicaid defines Non-Fraud Recovery as: "Investigation by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud." These cases are referred to DMAS when there is reason to suspect that an overpayment has occurred. **(42 CFR§431).**

B. Recovery of Misspent Funds

DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. The situations in which recovery of expenditures are possible include, but are not limited to:

- when eligibility errors are due to recipient misunderstanding,
- when agency errors are made, or
- when medical services are received during the appeal process and the agency's cancellation action is upheld.

C. Recovery of Funds Correctly Paid

Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients

1. Deceased Recipient's Estate

Under federal regulations and state law, DMAS may make a claim against a deceased enrollee's estate when the recipient was age 55 or over. The recovery can include any Medicaid payments made on his/her behalf. This claim can be waived if there are surviving dependents. **(42 CFR 433.36; Va. Code §32.1-326.1 and 32.1-327).**

Section 1917(b)(1)(C)(ii) of the Social Security Act was amended by the Deficit Reduction Act of 2005 to exempt assets disregarded under a "qualified" Long-term Care (LTC) Partnership Policy from estate recovery, as defined in clause (iii) of 1917(b)(1)(C). The same amount of assets that was disregarded in the Medicaid eligibility determination for an individual under an LTC Partnership Policy will be protected during estate recovery.

2. Uncompensated Property Transfers

DMAS may seek recovery when a Medicaid *enrollee* transferred property with an uncompensated value of more than $25,000. The transferees (recipients of the transfer) are liable to reimburse Medicaid for expenditures up to the uncompensated value of the property or resource. The property transfer must have occurred within 30 months of the recipient (transferor) becoming eligible for or receiving Medicaid. **(Va. Code §20-88.02).**

3. Local DSS Referral

When an agency discovers a Medicaid case involving property transfers, a Notice of Medicaid Fraud/Non-fraud Overissuance (form # DMAS 751R; see M1700, Appendix 1) must be completed and sent to:

Supervisor
Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Estate recoveries *and cases involving insurance-related recoveries* must be referred to:

Department of Medical Assistance Services
Attn: Third Party Recovery Unit
600 East Broad Street, Suite 1300
Richmond, VA 23219

or by e-mail to TPLunit@dmas.virginia.gov.

M1700.400 RESPONSIBILITY OF THE LOCAL DSS

A. Introduction

DMAS shares an interagency agreement with the *Virginia* Department of Social Services (VDSS) which lists specific responsibilities. Local departments of social services are responsible for referring and reporting the following situations to DMAS:

- Investigations "by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud"; and
- Instances where there is evidence that fraud may exist.

B. VDSS Responsibilities

To assist in the prevention of receipt of non-entitled services by enrollees, VDSS must use the "Notice of Medicaid Fraud/Non-fraud Overissuance" to:

- Notify DMAS of every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement;
- Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014);
- Notify DMAS of all instances in which a Medicaid recipient is a beneficiary of a discretionary trust and the trustee refuses to make the assets available for the medical expenses of the recipient, or when a Medicaid recipient has been found to be ineligible for Medicaid benefits as a result of a transfer of assets; and
- Include Medicaid expenditures in the computation of misspent funds, where a withholding or a deliberate misrepresentation of a pertinent fact has taken place and where a local social service agency will exercise jurisdiction in regard to prosecution of the case.

C. Recipient Audit Reporting

The Recipient Audit Unit has two prevention efforts for reporting fraud and abuse of Medicaid services. Either may be used by DSS for reporting fraud and abuse ***in conjunction with*** *the "Notice of Medicaid Fraud/Non-fraud Overissuance."*

- *Referrals may be made through the web address, recipientfraud@dmas.virginia.gov.*
- *Referrals may also be made through the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.*

***D.* Statute of Limitations**

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud should be flagged to ensure that the information is not purged. Cases cannot be properly investigated without specific documents, i.e. signed applications, bank statements, burial or insurance information. DMAS will notify the agency of the results of the fraud investigation.

NOTICE OF RECIPIENT FRAUD/NON-FRAUD OVERISSUANCE

DATE: _____/_____/_____

TO: RECIPIENT AUDIT UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

TYPE OF REFERRAL
Agency Error____
LTC Underpayment____
Drug Related____
Other____

Case Name: _____

Case Address: _____

_____

_____

Case Name Social Security #:_____

Medicaid ID#: ☐☐☐ - ☐☐☐☐☐☐ - ☐☐ - ☐

(Check appropriate box below)

☐ **Ineligible for Medicaid** **Dates: _____**
(*Explanation of Ineligibility in summary section)*

☐ **Underpayment for Medicaid LTC (*List months, amounts and explanation in summary section*)**

Summary:

_____

_____

_____

_____

_____ (___)_____
Eligibility Worker/Medicaid Technician **Telephone Number**

_____ _____
Address **City/County Code (FIPS)**

_____

_____

***Please attach all documentation listed in M1700.200 B.1 to the referral form.* You will be contacted by the Recipient Audit Unit if follow-up is necessary.**

COMMONWEALTH of VIRGINIA

PATRICK FINNERTY
DIRECTOR

Department of Medical Assistance Services

600 EAST BROAD STREET
RICHMOND, VA. 23219
PHONE: (804) 786-7933
FAX: (804)225-4512

Medicaid Claims Request

Date:_____

Agency:_____
Worker's Name:_____
Phone No:_____

Recipient Audit Unit Supervisor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Supervisor:

I am conducting an investigation of the person(s) listed below for the time period indicated. Please forward proof of claims paid by Medicaid during the investigative period, *if claims exceed the $300.00 threshold (worker will be notified by telephone if claims are below the threshold).*

Custodian Certificate/Claims needed? Y/N
Written referral following? Y/N
*Expected Date to the CA:*_____
*Expected Court Date:*_____

I will keep you informed of additional progress and of the outcome of this investigation.

Case Name:_____ Base ID#:_____

(a)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

(b)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

(c)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

(d)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

Sincerely,

CLAIMS REQUEST FORM INSTRUCTIONS

FORM NUMBER - DMAS 750R (7/08)

PURPOSE:

This form serves as a multi-purpose form. It can be used to receive certified claims from DMAS reporting the total expended amount of Medicaid services for the period of time in question. These claims are used in court testimony, as evidence against the defendant. Restitution is ordered based on the amount of claims in the form of a custodian certificate that is submitted by the supervisor of the Recipient Audit Unit. This information is notarized, and is attesting to the fact that the information is accurate and that the supervisor serves as the keeper of the records for DMAS. It can also be used if the agency would like to know if the claims exceed the Recipient Audit Unit amount of $300.00 for Medicaid-Only referrals. This is helpful in determining whether or not the case should be referred to the Recipient Audit Unit for investigation.

NOTE: Providers have up to one year to bill for services, therefore the amount of claims may not be accurate or complete at the time of prosecution or inquiry. It is suggested that the Commonwealth's Attorney be advised of this information, should additional claims develop at a later time and additional restitution be requested by DMAS.

USE OF FORM – Request of recipient claims for any investigation conducted by the local agency as it relates to person(s) receiving a money grant under the Temporary Assistance for Needy Families and Food Stamp program(s). Also, request for an estimate of claims when determining whether or not the Medicaid-Only case meets the RAU threshold requirements.

NUMBER AND DISTRIBUTION OF COPIES – Prepare original; make a copy for the agency record before sending to the Recipient Audit Unit at DMAS.

INSTRUCTIONS FOR PREPARATION OF FORM – The form should contain the case name, the base case ID number, each recipient ID number and the period of suspected fraud/overpayment for each recipient. Each recipient should be listed separately as shown on the form by the letters (a) through (d). Should there be additional recipients on the same base case ID, a second page should be attached.

The requestor must complete the *four* questions in the lower left corner of the form in order for DMAS to determine the priority of the request. *Failure to complete the questions will result in a delay of claims processing.*

The recipient(s) should be referred to DMAS if there was a period of time when the recipient was not eligible to receive benefits and the agency is unsure of how to handle the case.